TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEDALERT OCCUPATIONAL MANAGEMENT INC.
JOSE TREVINO, MD

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-17-3188-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This dispute is being submitted because the Carrier has failed to review our medical bill within the 45 day time frame required by the 28 TAC §133.240…Date of Receipt was confirmed through conversation with the Carrier as well as USPS Tracking Receipt."

Amount in Dispute: $102.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been denied there was no proof of timely filing."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2016	CPT Code 99080-73 Work Status Report	$15.00	$0.00
	CPT Code 99212 Office Visit	$87.00	$0.00
TOTAL		$102.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.

3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - D10-The time limit for filing has expired.
   - D00-Based on further review, no additional allowance is warranted.
   - P13-Payment reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - W3-In accordance with TDI-DWC rule 134.,804, this bill has been identified as a request for reconsideration or appeal.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason codes "D10-The time limit for filing has expired."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent within the 95 day deadline.

The requestor submitted a letter dated June 27, 2017, that had a tracking number and Product & Tracking Information that indicates item was delivered on January 30, 2017. The Division finds that the requestor did not sufficiently support position that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	7/26/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.